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CARDINAL HEALTH

RETAIL PHARMACY
SELF-QUESTIONNAIRE

I. GENERAL

1. Form completed By (Name)/Date	Lynnette Bunyan	2/21/08
2. Pharmacy Name	T & J Enterprises, Inc	
3. DBA ("doing business as" if name differs from corporate name or name on licenses)	The Medicine Shoppe #290	
4. Has pharmacy ever operated under a different name?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
5. If yes, what name(s)?		
6. Pharmacy Address	2402 Adams Ave, Huntington, WV 25904	
7. Pharmacy Phone	(304) 429-6716	
8. Pharmacy Fax	(304) 429-1924	
9. Name of Pharmacist in charge. (List all licensed staff in Section VI)	Joseph C. McClothlin, R.Ph.	
10. DEA Registration # of pharmacy	BT 5541760	
11. Does your pharmacy sell anything other prescription drugs (e.g., does the pharmacy have a front end)? If so, please describe what merchandise is sold (e.g., durable medical equipment; home healthcare aids, vitamins, cosmetics, etc.)?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, please describe: DME, Home Healthcare Aids, Vitamins, Medicine Shoppe line of OTC.	

II. OWNERSHIP

12. Ownership type (check one)	<input type="checkbox"/> Sole proprietor <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other
13. If corporation, indicate state of incorporation	West Virginia
14. Owner(s) name or Corporate Officers if a Corporation	Joseph C. McClothlin, President Neda McClothlin, Vice-President

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DEFENDANT
EXHIBIT

CAH-WV-00765

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15. Owner's Business Address	2402 ADAMS AVE, HUNTINGT, WV 25704
16. Owner's Phone	(304) 429-6716
17. Owner's Fax	(304) 429-1924
18. Number of years owner has operated pharmacy	
19. Is owner a licensed pharmacist? If so, please identify which State(s) and license number(s)	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO • State(name) <u>WV</u> Pharmacist License # <u>3911</u> • State(name) _____ Pharmacist License # _____ • State(name) _____ Pharmacist License # _____
20. Does owner operate/own any other pharmacies?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21. If yes, provide the following (Attach additional sheets as necessary)	
Name	
Address	
State and Pharmacy License #	
22. Pharmacy owner must sign a compliance agreement requiring the pharmacy to adhere to all rules and regulations regarding diversion (copy attached at end of this form). Will this agreement be signed and provided to Cardinal Health?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

III. PRIOR HISTORY AND ASSOCIATIONS

23. Has your pharmacy ever had a DEA registration suspended or revoked?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
a) If yes, provide details	
24. Has the pharmacy owner ever had a DEA registration suspended or revoked?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
a) If yes, provide details	

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IV. BUSINESS INFORMATION

25. Please provide a list of names of all pharmaceutical distributors pharmacy has used within the last 24 months	<i>Pharmed Pharma</i> <i>Andro Pharma</i>
26. Is the pharmacy affiliated with any other pharmacies or Internet websites?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
a) If yes, provide the following (Attach additional sheets as necessary)	
Name	
Address or URL Address	
Phone	
27. How does pharmacy receive business (check all that apply)?	<input checked="" type="checkbox"/> Internet <input checked="" type="checkbox"/> Fax <input type="checkbox"/> Mail Order <input checked="" type="checkbox"/> Phone <input checked="" type="checkbox"/> Walk in
a) For each type of business, what percentage of total business does that represent?	<u>1</u> % Internet <u>29</u> % Fax ___ % Mail Order <u>30</u> % Phone <u>40</u> % Walk in
28. Which states does pharmacy ship prescriptions into (if any)?	
29. Is pharmacy licensed for sales into states which it dispenses?	<input type="checkbox"/> YES <input type="checkbox"/> NO
a) If so, identify which states and provide the pharmacy license number(s) for those state(s).	State(name) _____ Pharmacy License # _____ State(name) _____ Pharmacy License # _____ State(name) _____ Pharmacy License # _____
30. Does pharmacy fill prescriptions for out-of-state patients?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
31. Does the pharmacy routinely fill prescriptions written by prescribers in other states?"	<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO
a) If yes, what % of prescriptions?	a) If yes, the percentage of prescriptions filled by your pharmacy for out-of-state prescribers is : ___ %

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b) If yes to No. 31(a), please provide the name(s) and address(es) of your most frequent out-of-state prescriber(s):

Name of Out-of-State Prescriber	Address	Prescriber's Name	Prescriber's DEA #

32. How many prescriptions does your pharmacy fill on average? Daily 250 Monthly

33. Hours of operation of pharmacy Monday - Friday 9:30-6:00 Saturday 9:30-1:00

34. Is the pharmacy a closed door pharmacy? ☐ YES ☒ NO

35. Does the pharmacy service nursing homes, long term care facilities ("LTFC"), hospice or other inpatient facilities? If so, describe.

Nursing Home	<input type="checkbox"/> YES	<input type="checkbox"/> NO
LTFC	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hospice	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
Other <u> </u>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

a) If yes, what percentage of the pharmacy's business is attributable to each of those types of facilities? Request copies of agreements.

Nursing Home	<u> </u> %
LTFC	<u> </u> %
Hospice	<u>1</u> %
Other <u> </u>	<u> </u> %

36. Does the pharmacy have a Internet web site? ☒ YES ☐ NO

a) If yes, provide web address 0290@medicineshoppe.com

37. How does pharmacy receive payment for products and in what approximate percentage?

Payment Method	YES	NO	% of Revenue
Insurance	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	<u>20%</u>
Medicare/Medicaid	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	<u>75%</u>
Cash	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	<u>5%</u>
Other	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<u> </u>

a) If other, provide details

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38. What % of pharmacy's prescription sales are controlled substances?

15%

39. Does the pharmacy service pain management clinics/nursing homes/long term care facilities (LTCF)/hospice?

Pn. Mgmt. Cl. ☒ YES ☐ NO
Nursing Home ☐ YES ☒ NOIf yes, how many nursing homes _____
How many beds per nursing home: _____LTCF ☐ YES ☒ NOIf yes, how many LTCF: _____
How many beds per LTCF: _____Hospice ☒ YES ☐ NO

a) If yes, list the following for each pain management clinic

Provide copy of contracts (if it exists) for hospice, LTCF and nursing home(s) and contact name at these institutions

Name of Clinic	Address of Clinic	Prescriber's Name	Prescriber's DEA #
CHH Regional Pain Management Center	1623 13th Ave Huntington, WV 25701	Dr. Ahmet Ozturk	B01101512
	2900 1st Ave Huntington, WV 25702	Dr. David Casaway	BC7126142

V. DESCRIPTION OF NEIGHBORHOOD

40. Is the pharmacy located within a medical center?

☐ YES☒ NO

41. Is the pharmacy located within a strip mall?

☐ YES☒ NO

42. General description of neighborhood (e.g., urban; rural; low income or upscale area; business district; residential area, etc.)

Residential Area

43. Are there hospitals, doctors' offices or medical clinics located in vicinity of the pharmacy?

Doctor Offices ☒ YES ☐ NO
Medical Clinics ☒ YES ☐ NO

a) If so, identify name, type, address, proximity to the pharmacy

Doctor Offices Dr. Greg Holmes 1/2 m.
Medical Clinics Valley Health Services 1/2 m.